Health Care Spending Benchmark Subcommittee
Monday, April 2, 2018
1:00 pm to 4:00 pm
DHSS Herman Holloway Campus – Chapel
1901 North DuPont Highway, New Castle, DE

Advisory Subcommittee Members Present:

- Secretary Kara Odom Walker (Chair)
- Tim Constantine
- Tom Corrigan
- Ryan Forman
- Nick Moriello
- Tom Brown
- James Gill
- Rich Heffron
- Faith Rentz
- Lisa Zimmerman
- Regina Mitchell

Advisory Subcommittee Members Absent:

- Nancy Fan (or designee)

State Staff Present:

- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Molly Magarik, Deputy Secretary, DHSS

Primary Consultants Present:

- Michael Bailit, President, Bailit Health
- Dianne Heffron, Principal, Mercer

I. Welcome and Introductions, Secretary Odom Walker

a. Secretary Odom Walker thanked the group for their participation. The Advisory Subcommittee members and staff introduced themselves.

II. Review of Open Meeting Law, Secretary Odom Walker

a. The subcommittee was reminded that any communication with other Advisory Group members is subject to disclosure through Freedom of Information Act (FOIA) requests, including any communications or meetings outside of this meeting.

III. Charge of the Subcommittee, Michael Bailit

a. The executive order background and purpose of the advisory group and subcommittee were reviewed.

b. The charge of the subcommittee was reviewed, which is to:

i. Provide input to the Advisory Group regarding the creation of a health care spending benchmark that will utilize a clear and operational definition of total health care spending for Delaware and make use of currently available data sources, and anticipate the use of new sources should they become available in the future.

ii. Be set at the state level and, as practicable, at the market (commercial, Medicare, Medicaid) insurer and health system/provider levels.
iii. Provide input to the Advisory Group regarding the creation of a health care spending benchmark that will tie a spending growth benchmark to an appropriate economic index; be established first for use for the first time for calendar year 2019, and then, annually thereafter; and be used in comparative analysis to actual spending following the end of calendar year 2019 and annually thereafter.

c. The subcommittee was reminded that the group will not be taking votes, and there does not need to be agreement on topics of conversation. The goal of the subcommittee is to advise the Advisory Group, which will then advise the Secretary.

d. The group will review existing data sources and anticipate future data sources to set a statewide benchmark and then, as practical, at a "larger entity" provider level.

e. The following questions were asked and corresponding responses were discussed on the charge:

i. Is this subcommittee creating a spending cap for next year?
Response: No. The health care spending benchmark will not be a spending cap.
ii. Will out-of-state individuals be included in the measures?
Response: The issue will be discussed later in the meeting.
iii. The benchmark year is 2019; is it the intention to rebase 2019?
Response: There is no base that will be locked in. The expectation is that 2019 is compared to 2018, 2020 compared to 2019, 2021 compared to 2020 and so on.
iv. What is the difference between a spending cap and the benchmark?
Response: This process is intended to develop a benchmark that will serve as a target (goal) for annual change in health care spending in Delaware.

IV. Total Healthcare Spending, Michael Bailit

a. State examples were discussed. Massachusetts is the only state to have adopted a spending benchmark, so it is the only point of reference. Rhode Island is currently conducting a process like this one. Delaware needs to do what is right for Delaware.

b. A cost growth benchmark is predicated on understanding total spending on health care. This allows comparison of year-over-year change to the benchmark. In thinking about total health care spending, all populations should be considered; outlays for health care spending should be considered (not provider revenues or costs).

c. Population health care spending was discussed. The group was asked to think about whether any populations under the following categories of coverage should be excluded, including associated pros and cons: Medicare (FFS Parts A, B, D), Medicare Advantage, Medicaid, CHIP, Medicare and Medicaid Dually Eligible, Commercial (fully insured, self-insured, Choose Health Delaware), Veterans Health Administration, FEHB, TRICARE and Uninsured.

i. There was general consensus that at least the four large groups of Medicaid, Medicare, Dual Eligibles and Commercial populations be included. Other populations need further consideration as well as the trade-offs between associated spending and administrative effort to obtain required data.

d. The following questions and comments were asked and corresponding responses were discussed on population health care spending:

i. How will charity care be considered?
Response: It is an outlay for the provider, but not the individual/payer sponsor. Our focus is on spending by consumers and purchasers.

ii. It was suggested that the focus of this exercise be first on a single population and then expand.
Response: The Governor has engaged stakeholders across the health care spectrum, and the consensus is that this should be done at a broad, statewide level. Employers, small businesses and others are all being impacted by the cost of health in addition to Medicaid and the State Employees' program.

iii. There is concern that there may be outlier reasons that providers do not measure well against the measure.
Response: The purpose is to set a target for the State, not for individual providers.

iv. It was recommended that the measure should include commercial data.

v. Is worker's compensation included in the Massachusetts's model?
Response: The belief is that this is not included in Massachusetts. It was mentioned that worker's comp is a totally different system.

vi. A comment was made that it is difficult to control for social determinants of health.

vii. A comment was made that it is challenging to have quality and spending benchmark discussions separately.

viii. It was recommended that charity care be included in the measure.

e. The group was asked whether the following spending categories with claims-based data should be included in the measure: hospital (inpatient and outpatient), physician, other professionals, home health and community health, long-term care, dental, pharmacy, durable medical equipment and hospice.

f. The following questions and comments were asked and corresponding responses were discussed on categories of health care spending on claims-based data:

i. Massachusetts had one bad year for pharmacy; how can this process account for new high-cost drugs?
Response: Massachusetts included pharmacy because it is a substantial part of costs. Massachusetts was able to drill down in its data and determine that a key driver was the introduction of high-cost hemophilia drugs, which provided an explanation and transparency.

ii. It was suggested that pharmacy should be included with the ability to track new high-cost drugs.

iii. There was a discussion that dental and vision are more difficult to extract individually from data, and incorporating standalone policies complicates the process.

iv. It was suggested that evaluation of the uninsured is more complex.

v. LTSS is a big part of Medicaid spending and should be included in the categories of spending reviewed.

vi. It was suggested to "keep it simple" and include all services, as extracting/excluding something may be more difficult.

vii. There was consensus that the group was leaning towards including all spending categories.

g. The group was asked whether the following spending categories with non-claims based data should be included: performance incentive payments, prospective payments for health care services (e.g., capitation), payments that support care transformation (e.g., care manager payments), payments that support provider services (e.g., DSH payments), prescription drug rebates/discounts, net cost of private health insurance and/or patient cost sharing for eligible populations.

h. The following questions and comments were asked and corresponding responses were discussed on including non-claims-based data:

- **i.** For prescription drug rebates, is spending seen as gross or net?
  Response: Insurers reported data to Massachusetts that was net of rebates.
- **ii.** There were concerns about double counting when looking at patient portion of cost sharing, charity care and uncompensated care.
- **iii.** There was general support to include the net cost of private health insurance and patient/member cost sharing.
- **iv.** There was concern that performance incentive payments to providers would be included and that providers would be, therefore, "penalized" for good performance.
  Response: It is an outlay, even though it is a "good" outlay.
- **v.** Should correctional health care spending be included?
  Response: It is not included in Massachusetts. It is unclear how money flows in Delaware; if it is State funding only, then this can be tracked. There was general support to include it, if practical.
- **vi.** On Federal grants, it was recommended that this be included unless it is for research purposes (e.g., NIH), but concern how this could be easily identified.
- **vii.** A concern was expressed about finding a balance between being comprehensive in what expenditures are included in the benchmark versus creating a process that is too complicated to administer.
- **viii.** For capitation of risk settlements, large health systems have shared savings which sometimes occurs months later. However, there is interest here in understanding immediate comparisons. There was a suggestion of performing an interim calculation and a final calculation to allow for information to be made available publicly, but also to have the benefit of additional time to collect data for the final benchmark comparison.
- **ix.** There was a suggestion that carve-outs be included.

V. Data Sources, Michael Bailit

a. The source of data for the cost benchmark was discussed, including the Massachusetts example. In Massachusetts, commercially insured expenditures include 10 largest commercial payers, commercial payers offering MassHealth (Medicaid) and Medicare Advantage plans. The publicly insured expenditures include CMS (Medicare), MassHealth FFS and MassHealth MCOs, Health Safety Net (pays acute care hospitals and community health centers for certain services provided to qualified uninsured and underinsured residents), Medical Security Program (for eligible state unemployment insurance recipients) and Veterans Affairs. Massachusetts has statutory authority to collect data.

b. The subcommittee discussed that a Supreme Court ruling noted that self-insured claim-level data must be submitted to a state voluntarily.

c. Detailed claims level data may not be needed. Summary level data may be okay. A comment was made regarding the potential administrative burden on insurers/payers to provide data.

d. Highmark offered to provide data voluntarily. Four insurers in Delaware represent a vast majority of the commercially insured population, so although the data does not cover the entire population, it is a good representation.

e. There are a limited number of data sources available. A Delaware all-payer claims database (APCD) may, in time, be a future source.

f. A topic was raised whether the data should be voluntary or mandatorily reported via legislation, contracts, etc. The pros and cons of each were discussed.

g. The following questions and comments were asked and corresponding responses were discussed on including non-claims-based data:

i. It was recommended that Medicare supplemental plans be included.
Response: This is already captured as part of Medicare data.

ii. Is the group confident that timely Medicare data will be available?
Response: Yes, Massachusetts is able to obtain timely Medicare data, and the State is already conversing with CMMI colleagues about data access.

VI. Unit of Measure, Michael Bailit

a. The Executive Order states that the health care spending benchmark will be set at the state level, and, as practicable, at the market (commercial, Medicare, Medicaid), insurer and health system/provider levels. The "as practicable" language applies to assessing performance against the benchmark, rather than setting the benchmark.

b. To report health care spending at the state level, there are two decisions that need be considered: 1. What is the numerator? and 2. What is the denominator? To address both, the group must ask what is the residence of the patient and what is the location of the care provider?

c. The group was asked to consider some options of patient/provider locations. The group discussed pros and cons of different permutations of including different providers and patients in the measure.

d. The following questions and comments were asked and corresponding responses were discussed on units of measure:

i. Where would a large substance use agency fit?
Response: A large substance use treatment agency would not be assessed individually, but would have its spending considered as its relates to serving patients with primary care relationships at large providers and systems.

ii. Are trends on emergency care useful?
Response: There is opportunity to understand that, but the spending benchmark itself will not do that (potential to drill down into the data though).

iii. Are there lessons learned on non-attributed individuals?
Attribution logic concerns were discussed for potential reporting at a provider level, along with risk adjustment/acuity changes over time.

iv. Who is a patient attributed to?
Response: A primary care clinician associated with a provider contracting entity.

e. There was consensus that the spending benchmark should cover in-state and out-of-state spending for Delaware State residents only.

VII. Public Comment

a. No public comments were submitted.

VIII. Wrap-up and Next Steps, Secretary Odom Walker

a. Comments may be submitted via email.

b. The recommendations will be compiled and shared with the full advisory group at the next meeting.

c. Before the next meeting, there will be information provided on the market sources for coverage.

d. One individual stated that his presence did not constitute a real or implied endorsement of the benchmark strategy.